



South Dakota Board of Nursing  
 South Dakota Department of Health  
 4305 South Louise Avenue Suite 201  
 Sioux Falls SD 57106-3115  
 (605) 362-2760 Fax: (605) 362-2768

Nurse Aide  
**Application for *Faculty Changes* to a Currently Approved Training Program**

**\*Allow up to 5-7 business days for the SDBON to process your application\***

Approved programs must submit, within 30 days after a change, any substantive changes made to the program during their 2-year approval period. Written approval or denial of a requested change will be issued within 90 days after receipt of the application.

Name of Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail Address of **Program Coordinator**: \_\_\_\_\_

Email Address of **Primary Instructor**: \_\_\_\_\_

- ☐ **Request New Program Coordinator** must be a registered nurse with 2 years nursing experience, at least one of which is in the provision of long-term care services. The Director of Nursing (DON) may serve simultaneously as the program coordinator but may not perform training while serving as DON. (ARSD 44:74:02:10)
- ☐ Attach curriculum vita, resume, or work history

| Name of Program Coordinator | RN LICENSE |        |                 |                                      |
|-----------------------------|------------|--------|-----------------|--------------------------------------|
|                             | State      | Number | Expiration Date | Verification<br>(Completed by SDBON) |
|                             |            |        |                 |                                      |

- ☐ **Request New Primary Instructor** as actual teacher of course material; must be a RN or LPN with 2 years nursing experience, at least one of which is in the provision of long-term care services. (ARSD 44:74:02:11)
- ☐ Attach curriculum vita, resume, or work history,
- ☐ Attach documentation supporting previous experience in teaching adults within the past 5 years or documentation of completing a course in the instruction of adults.

| Name of Primary Instructor | RN OR LPN LICENSE |        |                 |                                      |
|----------------------------|-------------------|--------|-----------------|--------------------------------------|
|                            | State             | Number | Expiration Date | Verification<br>(Completed by SDBON) |
|                            |                   |        |                 |                                      |

- ☐ **Request New Supplemental Personnel** to assist with instruction, they must have one year of experience in their respective field of practice, i.e. additional licensed nurses, social worker, physical therapist. (ARSD 44:74:02:12)
- ☐ Attach curriculum vita, resume, or work history.

| Supplemental Personnel & Credentials | LICENSURE/REGISTRATION |        |                 |                                      |
|--------------------------------------|------------------------|--------|-----------------|--------------------------------------|
|                                      | State                  | Number | Expiration Date | Verification<br>(Completed by SDBON) |
|                                      |                        |        |                 |                                      |
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**Program Coordinator Signature:**\_\_\_\_\_ **Date:**\_\_\_\_\_

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**This section to be completed by the South Dakota Board of Nursing**

|                                  |                          |
|----------------------------------|--------------------------|
| Date Application Received:       | Date Application Denied: |
| Date Approved:                   | Reason for Denial:       |
| Expiration Date of Approval:     |                          |
| Board Representative:            |                          |
| Date Notice Sent to Institution: |                          |